THE UNIVERSITY OF CHICAGO | Finance and Administration Division
Office of Risk Management

Effective 07/2019
Questions about this form?
Contact Risk Management
Email: WCclaim@uchicago.edu

Supervisor's First Report – Workers' Compensation Claim of Injury/Illness

PLEASE PRINT

Department: _____ **Date Notified of Injury/Illness:** ___/___/20__

Employee Name: _____ **Job Title:** _____ **Union:** _____

Date Hired to Present Position: ___/___/____ **Last Day Worked:** ___/___/20__

Date of Injury/Illness/Accident: ___/___/20__ **Time:** ___:___ **AM/PM M-F Accident: Yes / No**

Specific Location of Accident: (address, building name, area in building or grounds): _____

_____

What did the employee state happened? _____

_____

_____

Was the reported activity within the scope, responsibilities, duties and course of employment? Yes / No

List any equipment or tools the employee reports using at the time, if applicable: _____

_____

Identify contributing factors, if any at the time: _____

_____

List all injuries, where on the employee's body or nature of illness: _____

_____

Did the employee miss one or more full work day(s) as a result of this incident? Yes / No

If yes, provide specific dates and date of return to work: _____

Did the individual return to work with limitations? _____

List reported witnesses and co-workers present, include contact information: _____

_____

First person notified of injury/illness/accident: _____

Reported via UCAIR: Yes / No By: _____ **Date:** ___/___/20__

Reported to Office of Research Safety or Environmental Health & Safety: Yes / No

By: _____ **Date:** ___/___/20__

Employee sent for medical attention: Yes / No If yes, ER / UCOM Clinic

Form completed by: _____ **Date:** ___/___/20__